STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME	203 FRANCISCAN DRIVE CROWN POINT, IN46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/07/1 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, St. Anthony Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility with a partial basement was determined to be of Type I (332) construction	K0000	St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity for 198 and had a census of 178 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/10/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure openings through a smoke barrier wall on 1 of 3 floors was sealed to maintain the smoke	K0025	K025 **Facility respectfully requesting an extension of time for corrective action in this tag area that will take less than ninety (90) days to complete.** 1.1 The gap in the concrete	07/07/2011

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	resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe be protected so that the space between the penetrating and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 15 residents on 3B. Findings include: Based on observation with the maintenance director on 06/07/11 at 1:00 p.m., a cut out had been made in the concrete smoke barrier on 3B to allow for the passage of a four inch pipe above the laid in ceiling in resident room 333. A gap of six inches had not been sealed around the penetration. The maintenance director said at the time of observations, there was and had been ongoing upgrades made to plumbing and sprinkler systems and the facility was in the process of identifying and correcting these		smoke barrier on 3B above the laid in ceiling in resident room 333 was sealed by the Plant Operations department on 6/7/11. 1.2 Facility formally requesting an extension of time to complete corrective action related to LSC Section 8.3.6.1 based on size of facility, number of smoke barriers and time frame needed to adequately correct any other possible deficiencies. Due to the overall square footage (in excess of 167,000 sq. ft.) and complexity of the facility (it was built in several phases from 1962 to 1975), both the audit to determine where unprotected openings exist in the smoke barriers, and the measures needed to correct the discovered deficiencies (without a significant disruption in resident care), require an extension to 8/8/11. The Director of Plant Operations / designee will complete the audit of the existing smoke barriers by 6/23/11. This completed audit will serve as a work scope for securing pricing from qualified contractors with contractor selection to be completed by 6/24/11. The corrective measures will be completed in a systematic fashion by area (wing and floor) to maintain resident/staff/visitor safety with any other correction needed completed by 8/5/11. Staff final review of completed work to ensure compliance to be completed, and complete deficiency correction by 8/8/11.	

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	issues. He had not yet identified this unsealed opening. 3.1-19(b)		Additional inspections of the facility have and are being undertaken to maintain that systems and procedures are in keeping with necessary life safety requirements. Additional staff fire safety awareness and education completed as it relates to best safety practices. 1.3 Director of Plant Operations / designee reviewed and revised the facility repair / construction / renovation policy given to contractors prior to repair / construction / renovation projects to more clearly include requirement of sealing of gaps in smoke barriers. Director of Plant Operations / designee re-inserviced identified vendors and staff regarding sealing of gaps in smoke barriers by 6/27/11. Director of Plant Operations will monitor repair / construction / renovation projects for compliance with sealing of gaps in smoke barriers beginning week of 6/27/11. 1.4 Director of Plant Operations will report findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held by 7/7/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/7/11.	

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K0038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 17 of 27 exit doors equipped with delayed egress locks were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects visitors and 50 or more residents on the first, second and third floors. Findings include:	K0038	K038 1.1 Exit codes for keypad overrides for identified exit doorways were posted by 6/8/11. 1.2 The Director of Plant Operations / designee checked remaining exit doorways by 6/8/11 for keypad overrides that require posting of exit code with any deficiencies noted corrected at that time. 1.3 The Director of Plant Operations / designee re-inserviced staff regarding requirement of posting code at exit doorways with keypad overrides by 6/27/11. The Director of Plant Operations / designee will audit exit doorways with keypad overrides weekly to ensure code is posted beginning week of 6/27/11 for six (6) months. 1.4 Director of Plant Operations will report findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held by 7/7/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/7/11.	07/07/2011

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	Based on observations with the maintenance director on 06/07/11 between 11:15 a.m. and 3:40 p.m. emergency exit doors on all three resident use floors were magnetically locked. The maintenance director demonstrated the locks would release by entering a code on a keypad for all locks except three accessing stairways adjacent to the elevators. These exit door locks could be over ridden to open when a special employee identification code was passed over a box adjacent to the stairway exit doorways. The exit code for keypad over rides were not posted. The maintenance director said at the time of observations, floors with alert and mixed occupancy residents were expected to use the elevators and main first floor doors. They didn't want anyone to use the other exit doorways unless there was an emergency. He said, and later demonstrated, the doors released upon activation of the fire alarm system. 3.1-19(b)			

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K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to provide documentation to evidence all staff participated in quarterly fire drills during 3 of the past 4 quarters. This deficient practice affects all occupants. Findings include: Based on a review of fire safety records provided for the past year with the maintenance director on 06/07/11 at 3:50 p.m., fire drills were conducted every shift each month, however, signatures of participating staff did not appear to reflect the number of staff on duty in all departments for the fire drills. There was no means by which to verify the participation and training all staff at least	K0050	K050 1.1 Most current fire safety record was reviewed by the Director of Plant Operations on 6/7/11 with no negative outcomes noted related to signatures of participating staff not appearing to reflect the number of staff on duty in all departments for the fire drill. 1.2 Previous quarter's fire safety records were reviewed by the Director of Plant Operations by 6/8/11 with no negative outcomes noted related to signatures of participating staff not appearing to reflect the number of staff on duty in all departments for the fire drills. 1.3 The Director of Plant Operations / designee re-inserved staff regarding signatures of staff on duty in all departments when conducting fire drills by 6/27/11. The Director of Plant Operations / designee will collaborate with HR / Payroll or designee to obtain list of staff on duty for all departments prior to conducting	07/07/2011

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	quarterly. The maintenance director said at the time of record review, the issue of documenting all participating staff for each drill had been identified but not resolved. The annual fire plan inservice did include the participation of all staff. 3.1-19(b) 3.1-51(c)		fire drills and will then obtain documentation of participation in the fire drill from each identified staff member beginning the week of 6/27/11. The Director of Plant Operations / designee will audit fire drills monthly for six (6) months to ensure signatures of staff on duty in all departments beginning in July 2011. 1.4 The Director of Plant Operations / will report findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held by 7/7/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/7/11.	
K0062 SS=D	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 8 of 9 kitchen sprinkler heads were free of foreign materials such as grime. NFPA 25, 2-2.11 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects 4 kitchen staff. Findings include:	K0062	K062 1.1 Plant Operations cleaned identified kitchen sprinkler heads by 6/8/11. 1.2 Plant Operations assessed remaining facility sprinkler heads the week of 6/13/11 with any deficiencies noted corrected at that time. 1.3 The Director of Plant Operations / designee re-inserviced staff regarding sprinkler heads free of foreign materials such as grime by	07/07/2011

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	Based on observation with the maintenance director on 06/07/11 at 3:20 p.m., eight of the nine sprinkler heads in the dishwashing area of the kitchen were coated with a brown greasy appearing grime. The maintenance director said at the time of observation, he was surprised at their condition because he thought these heads had been replaced by the sprinkler contracting company. 3.1-19(b)		6/27/11. The Director of Plant Operations / designee will audit all sprinkler heads in the kitchen every other week beginning week of 6/27/11 for six (6) months and twenty (20) sprinkler heads per floor outside of the kitchen monthly beginning July 2011 for six (6) months. 1.4 The Director of Plant Operations / will report findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held by 7/7/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/7/11.	
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure annual and monthly checks were provided for 5 of 153 portable fire extinguishers. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4-2.2 defines maintenance as a "thorough	K0064	K064 1.1 The Director of Plant Operations / designee completed monthly checks on portable fire extinguisher #139, #140, #141 and #145 on 6/7/11. 1.2 The Director of Plant Operations / designee audited all remaining portable fire extinguishers to ensure compliance with monthly inspection on 6/7/11 with any deficiencies noted corrected at that time. 1.3 The Director of Plant Operations / designee	07/07/2011

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	check" of the extinguisher. It is intended to give maximum assurance that extinguisher will operate effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect affect visitors, staff and 38 residents on 3A and 3B. Findings include: Based on observation with the maintenance director on 06/07/11 between 11:15 a.m. and 12:30 p.m., the service and inspection tags on the portable fire extinguishers identified as 139, 140, 141, and 145 each noted the last monthly check had been done 04/27/11. A fire extinguisher in the 3B medicine room noted a 10/22/10 monthly check. The maintenance director said at the time of observation, the fire extinguishers should have had timely monthly inspections.		re-inserviced staff regarding monthly inspections of portable fire extinguishers by 6/27/11. The Director of Plant Operations / designee will audit portable fire extinguishers monthly for compliance with monthly inspections for six (6) months beginning July 2011. 1.4 The Director of Plant Operations / will report findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held by 7/7/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/7/11.	

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	Based on observation with the maintenance director on 06/07/11 at 1:00 p.m., the service and inspection tag on the portable fire extinguisher located in the 3B medicine room indicated the last annual inspection date was December of 2009. The maintenance director said at the time of observation, he had no idea the outdated fire extinguisher was in the room. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6	K0144	K144 1.1 The Director of Plant Operations / designee assessed current documentation related to operation of emergency generator on 6/7/11 with no negative outcomes noted. 1.2 The facility has no additional emergency generators. Upon notification regarding the emergency generator shut off device, Director of Plant Operations / designee obtained bid and placed order for a remotely located emergency generator shut off device and will	07/07/2011

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	requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on review of the generator maintenance records on 06/07/11 at 3:10 p.m. with the maintenance director, there was no documentation available indicating the horsepower of the generator. The maintenance director said at the time of record review, he was sure the generator engine was rated for more than 100 horsepower. Based on observation of generator equipment on 06/07/11 at 2:50 p.m. with the maintenance		install same by 7/7/11. 1.3 The Director of Plant Operations / designee re-inserviced staff regarding remotely located emergency generator shut off devices by 6/27/11. The Director of Plant Operations / designee will expand monthly preventive maintenance program to assess functionality of emergency generator monthly for six (6) months beginning July 2011. 1.4 The Director of Plant Operations / will report findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held by 7/7/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/7/11. 2.1 The Director of Plant Operations / designee assessed current documentation related to operation of emergency generator on 6/7/11 with no negative outcomes noted. 2.2 The facility has no additional emergency generators. Upon notification of need for alarm annunciator to be in a location readily observed by operating personnel at a regular work station, Director of Plant Operations / designee obtained bid and placed order for same	

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	director, the generator was not equipped with a remotely located emergency generator shut off device. The maintenance director immediately called the generator contractor who verified the generator would have to have one added. 3.1-(19) b 2. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or		and will install by 7/7/11. Temporary access provided to identified midnight shift staff to allow for access to existing alarm annunciator when maintenance staff not in building until additional annunciator installed. 2.3 The Director of Plant Operations / designee re-inserviced staff regarding alarm annunciators in a location readily observed by operating personnel at a regular work station by 6/27/11. The Director of Plant Operations / designee will expand monthly preventive maintenance program to assess functionality of emergency generator monthly for six (6) months beginning July 2011. 2.4 See 1.4 above. 2.5 See 1.5 above.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all patients, visitors and staff. Findings include: Based on observation with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/07/2011

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	maintenance director on 06/07/11 at 2:15 p.m., a remote alarm annunciator for the emergency generator was provided in the facility maintenance shop. The maintenance director said at the time of observation, the maintenance department was staffed until 11:00 p.m., but the staff were in and out of the shop, and there was nobody to observe or hear the alarm after 11:00 p.m. 3.1-(19) b			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 43 residents on the 3A and 3B. Findings include:	K0147	K147 1.1 On 6/7/11 the Director of Plant Operations / designee removed flexible cords from rooms A319, A300 and C352. 1.2 The Director of Plant Operations / designee checked remaining rooms for flexible cords in use as a substitute for fixed wiring with any deficiencies noted corrected at that time. 1.3 The Director of Plant Operations / designee re-inserviced staff regarding not using flexible cords as a substitute for fixed wiring by 6/27/11. The Director of Plant Operations / Social Service Department / designee will audit	07/07/2011

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	Based on observations with the maintenance director on 06/07/11 at 11:15 a.m. and 1:250 p.m., power strip extension cords were observed in use under the resident bed in A319; adjacent to the resident bed in A300 to power a nebulizer and electric bed; and adjacent to the bed in C352 to provide power for a nebulizer and oxygen concentrator. The maintenance director said at the time of observation, the power strips were not approved for the use and staff were aware of this. 3.1-19(b)		five (5) rooms per unit weekly for six (6) months to ensure flexible cords not in use as a substitute for fixed wiring beginning the week of 6/27/11. 1.4 The Director of Plant Operations / will report findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held by 7/7/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/7/11.	